

if, for instance, the only alternative is daily transportation by ambulance.

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985]

§ 409.36 Effect of discharge from posthospital SNF care.

If a beneficiary is discharged from a facility after receiving posthospital SNF care, he or she is not entitled to additional services of this kind in the same benefit period unless—

(a) He or she is readmitted to the same or another facility within 30 calendar days following the day of discharge (or, before December 5, 1980, within 14 calendar days after discharge); or

(b) He or she is again hospitalized for at least 3 consecutive calendar days.

Subpart E—Home Health Services Under Hospital Insurance

§ 409.40 Basis, purpose, and scope.

This subpart implements sections 1814(a)(2)(C), 1835(a)(2)(A), and 1861(m) of the Act with respect to the requirements that must be met for Medicare payment to be made for home health services furnished to eligible beneficiaries.

[59 FR 65493, Dec. 20, 1994]

§ 409.41 Requirement for payment.

In order for home health services to qualify for payment under the Medicare program the following requirements must be met:

(a) The services must be furnished to an eligible beneficiary by, or under arrangements with, an HHA that—

(1) Meets the conditions of participation for HHAs at part 484 of this chapter; and

(2) Has in effect a Medicare provider agreement as described in part 489, subparts A, B, C, D, and E of this chapter.

(b) The physician certification and recertification requirements for home health services described in § 424.22.

(c) All requirements contained in §§ 409.42 through 409.47.

[59 FR 65494, Dec. 20, 1994]

§ 409.42 Beneficiary qualifications for coverage of services.

To qualify for Medicare coverage of home health services, a beneficiary must meet each of the following requirements:

(a) *Confined to the home.* The beneficiary must be confined to the home or in an institution that is not a hospital, SNF or nursing facility as defined in section 1861(e)(1), 1819(a)(1) or 1919(a)(1) of the Act, respectively.

(b) *Under the care of a physician.* The beneficiary must be under the care of a physician who establishes the plan of care. A doctor of podiatric medicine may establish a plan of care only if that is consistent with the functions he or she is authorized to perform under State law.

(c) *In need of skilled services.* The beneficiary must need at least one of the following skilled services as certified by a physician in accordance with the physician certification and recertification requirements for home health services under § 424.22 of this chapter.

(1) Intermittent skilled nursing services that meet the criteria for skilled services and the need for skilled services found in § 409.32. (Also see § 409.33(a) and (b) for a description of examples of skilled nursing and rehabilitation services.)

(2) Physical therapy services that meet the requirements of § 409.44(c).

(3) Speech-language pathology services that meet the requirements of § 409.44(c).

(4) Continuing occupational therapy services that meet the requirements of § 409.44(c) if the beneficiary's eligibility for home health services has been established by virtue of a prior need for intermittent skilled nursing care, speech-language pathology services, or physical therapy in the current or prior certification period.

(d) *Under a plan of care.* The beneficiary must be under a plan of care that meets the requirements for plans of care specified in § 409.43.

(e) *By whom the services must be furnished.* The home health services must be furnished by, or under arrangements made by, a participating HHA.

[59 FR 65494, Dec. 20, 1994; 60 FR 39122, Aug. 1, 1995]